

PB_Name: Cathy Sample
PB_Address1: 650 Sample Ave NE
PB_CityStateZip: Main, WA 98270
PB_Insert_Feeder: 000000
PB_Server_ID: 9
PB_Job_ID:
PB_PlanetCode_ServiceCode: 40
PB_Mailing_ID:

DIRECT BILL OPEN ENROLLMENT NOTIFICATION

To Cathy Sample and Eligible Covered Dependents (if applicable) - 0908711000

The Sample Company, LLC is currently offering open enrollment for plan changes. You may make changes such as choosing different health plan options or adding/deleting coverage for family members. Enrollments are subject to verification of eligibility on elected health plans and may include rate or plan changes by your plan sponsor. Please use the enclosed form to make any changes to your current coverage and return it to WageWorks.

If you have any questions, please contact our Customer Service Center at 888-678-4881.

This form must be returned to WageWorks within two weeks of the date which it was mailed to you.

Client Name: Sample Company, LLC
Member Name: Cathy Sample

Client ID: 92400
Account Number: 0908711000

Section A. Description of Changes to Current Plans

<u>Plan Name</u>	<u>Coverage</u>	<u>Description of Changes</u>
DB Anthem PPO DMG WA	Individual Only	The premium for your continuation coverage will be changing as of the new plan year.
DB Cigna DPPO Dental Clinician	Individual Only	The premium for your continuation coverage will be changing as of the new plan year.

Section B. Plan Alternatives

Place an "X" in the box adjacent to the monthly cost of the coverage(s) you are selecting. NOTE: IF YOU ARE MAKING ANY CHANGES TO YOUR CURRENT COVERAGE YOU **MUST** SELECT EACH PLAN YOU INTEND TO CARRY IN THE NEW PLAN YEAR. Complete Sections C and D to indicate which individual(s) you wish to cover on the plans selected below.

Medical w/ Prescription - DB Medical - UMR EPO

Individual Only	Individual + Child(ren)	Individual + Spouse	Family
<input type="checkbox"/> \$760.79	<input type="checkbox"/> \$1,457.26	<input type="checkbox"/> \$1,612.03	<input type="checkbox"/> \$2,385.89

Medical w/ Prescription - DB Medical - UMR HDHP

Individual Only	Individual + Child(ren)	Individual + Spouse	Family
<input type="checkbox"/> \$709.63	<input type="checkbox"/> \$1,360.60	<input type="checkbox"/> \$1,505.26	<input type="checkbox"/> \$2,228.56

Medical w/ Prescription - DB Medical - UMR PPO with HRA

Individual Only	Individual + Child(ren)	Individual + Spouse	Family
<input type="checkbox"/> \$756.84	<input type="checkbox"/> \$1,449.75	<input type="checkbox"/> \$1,603.73	<input type="checkbox"/> \$2,373.64

Check here to Waive Medical w/ Prescription Coverage

Section C. Current Member Information

Please verify our records are accurate and make changes as necessary. You **MUST** select the plan type for each individual you intend to cover.

Current Member Name	Relationship	Gender
Sample, Cathy	Self	F
Medical w/ Prescription		
<input type="checkbox"/>		Delete Coverage <input type="checkbox"/>

Section D. Add Dependents

Please add any additional dependents you intend to enroll on your account and indicate the coverage requested. Each dependent added will be subject to eligibility verification prior to receiving coverage.

Dependent Name	Relationship	Birth Date	SSN	Gender	<input type="checkbox"/> Add
_____	_____	_____	_____	_____	
Medical w/ Prescription					
<input type="checkbox"/>					

Dependent Name	Relationship	Birth Date	SSN	Gender	<input type="checkbox"/> Add
_____	_____	_____	_____	_____	
Medical w/ Prescription					
<input type="checkbox"/>					

Client Name: Sample Company, LLC
Member Name: Cathy Sample

Client ID: 92400
Account Number: 0908711000

Dependent Name	Relationship	Birth Date	SSN	Gender	<input type="checkbox"/> Add
_____	_____	_____	_____	_____	
Medical w/ Prescription <input type="checkbox"/>					

Dependent Name	Relationship	Birth Date	SSN	Gender	<input type="checkbox"/> Add
_____	_____	_____	_____	_____	
Medical w/ Prescription <input type="checkbox"/>					

Dependent Name	Relationship	Birth Date	SSN	Gender	<input type="checkbox"/> Add
_____	_____	_____	_____	_____	
Medical w/ Prescription <input type="checkbox"/>					

Applicant's Authorization and Agreement

I attest that all information provided is correct. I understand that if I do not make the appropriate election(s) on this form, I cannot make changes for the upcoming plan year.

Applicant's Signature: _____ **Date:** _____

Print Name: _____

If you wish to change your coverage, your response is required.

For faster service fax to 866-450-5641 or enroll on line at: mybenefits.wageworks.com. Mail completed form to: WageWorks, Inc. P.O. Box 223684 Dallas, TX 75222-3684.